Oxnard Union High School District
PREPARTICIPATION PHYSICAL EXAMINATION FORM

Athlete Name: ______________________________ Date of Birth: ____________

EXAMINATION			
Height:	Weight:	BP: / (/)	Pulse:
Vision corrected: Y / N		Pupils equal: Y / N	

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis		
Neurological		

MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Hernia		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

[a]Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Allergies: ______________________ Regular Medications: ______________________

Comments: (asthma, diabetes, etc.) ______________________________________

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☐ **CLEARED FOR ATHLETICS** ☐ **NOT CLEARED- Reason:**______________________

Name of Examiner (print): ____________________State License#:__________ Date:________

Address: ______________________________________ Phone: ______________

Signature of health care professional: ______________________________, MD, DO, NP, or PA

Provider Stamp or Attached Business Card:

Last Name: ____________ First Name: ____________ Grade: ____________

Student ID#: ____________ Sport(s): ____________ School: ____________

*Parent/ Guardian and Student Consent on Next Page must be filled out by Parent and Student for athlete to be cleared.

Parent/Guardian and Student Consent

I hereby give my consent for ____, hereafter named student, to compete in athletics. I authorize the student to go with and be supervised by a representative of the school on any trips. In case this student becomes ill or is injured, you are authorized to have the student treated and I authorized the medical agency to render treatment. I consent to evaluation and treatment by the Certified Athletic Trainer, any X-ray examination, anesthetic, medical , or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under, the general or special supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any accredited hospital, whether such diagnosis or treatment is rendered at the office of said physician or said hospital it is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of the school representative to give specific consent to any and all such diagnosis, treatment or hospital care which aforementioned physician in the exercise of his/her best judgement may deem advisable. This authorization shall remain effective until the end of the school year unless sooner revoked in writing and delivered to the school.

Parent/ Guardian Signature: ____ Date:_________________

Student Signature: ____ Date:_________________